DOCUMENT RESUME

ED 308 441 CG 021 766

AUTHOR Berry, J. W.
TITLE Understanding the Process of Acculturation for Primary Prevention.
INSTITUTION Minnesota Univ., Minneapolis. Refugees Assistance Program - Mental Health Technical Assistance Center.
SPONS AGENCY National Inst. of Mental Health (DHHS), Rockville, MD.
PUB DATE Mar 88
CONTRACT NIMH-278-85-0024-CH
NOTE 29p.
AVAILABLE FROM Refugee Assistance Program--Mental Health Technical Assistance Center, University of Minnesota, Box 85, Mayo, Minneapolis, MN 55455.
PUB TYPE Information Analyses (070)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Acculturation; Asian Americans; Cambodians; Laotians; *Mental Health; Migration; Psychological Patterns; *Refugees; *Relocation; *Social Integration; Sociocultural Patterns; *Stress Variables; Subcultures; Vietnamese People
IDENTIFIERS Refugee Assistance; *Refugee Mental Health

ABSTRACT

This paper reviews the concepts of acculturation and adaptation to provide a framework for understanding the highly variable relationship between acculturation and mental health in refugee populations. It begins with an extended definition and discussion of the concepts of acculturation and adaptation. The characteristics of acculturating groups and dominant groups are briefly described, and a schema is developed to illustrate the concept of acculturative stress. Experiences related to psychological acculturation and adaptation are classified and described according to the phase of the acculturation process: pre-departure, flight, first asylum, claimant status, settlement, and adaptation. The paper concludes with five general observations on acculturation stress with regard to refugees: (1) they are powerless with respect to dominant groups both before and after departure; (2) countries of first asylum are often least able to assimilate new arrivals; (3) lack of voluntariness or mobility creates stress; (4) the probable sequence of acculturation for refugees is highly likely to lead to psychological and social problems; and (5) the major stressors are in the early phases of the refugee experience. References are included. (TE)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED308441

Understanding the Process of Acculturation For Primary Prevention

J.W. Berry, Ph.D.
Psychology Department
Queen's University
Kingston, Ontario
Canada, K7L 3N6

Prepared for the National Institute of Mental Health
Refugee Assistance Program - Mental Health: Technical Assistance Center
University of Minnesota
Contract No. 278-85-0024 CH
Santa Fe, New Mexico, Working Group on Refugee Mental Health, March, 1988

CG 021766

Outline

Introduction
Acculturation
Acculturating Groups
Dominant Groups
Acculturative Stress
Phases of Acculturation
Implications for Refugees
Conclusions
References

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Amos S. Donnal

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

INTRODUCTION

This paper attempts to provide an overview, from the perspective of cross-cultural psychology, of the factors that may govern the relationship between acculturation and mental health in refugee populations. One fundamental assumption of the paper is that individuals can move successfully between cultures (even refugees who have been exposed to traumatic experiences).

The emphasis is on primary prevention (the avoidance or reduction of problems by taking action before they develop), rather than on secondary or tertiary to avoid chronic complications). The paper is rooted in the social science tradition of attempting to understand a phenomenon as a function of the broad context in which it is situated; specifically, the goal is to understand mental problems (and its converse, successful psychological adaptation) as an outcome of the acculturation of refugees. The framework is a broad one, (encompassing acculturation experiences in the home country, during flight, while in countries of first asylum, and in the country of eventual settlement) and is concerned with a variety of outcomes (including mental problems, social deviance and difficulties in social relationships). Within this framework, we emphasize that there is a highly variable relationship between acculturation and mental health outcomes; problems are <u>not</u> inevitable since this relationship is affect by factors that can be understood, and to some extent managed, in order to achieve more positive results.

In preparing this overview, I have drawn upon academic reviews of this issue (e.g. Berry, 1986; Berry & Kim, 1988; Canadian Task Force 1986; Westermeyer, 1986; Williams, 1987), on some empirical research programmes (e.g. Beiser, 1986; Berry et al., 1987; Westermeyer, 1987), and on reports of recent consultations among refugee mental health personnel (e.g. League of Red Cross and Red Crescent Societies, 1986, 1987; Refugee Action, 1987).

My focus is that specified in the statement of goals and specific objectives for this Working Group: "to describe methods for facilitating acculturation, social integration and psychosocial rehabilitation of refugees" (Goal 1.3), and to suggest "guidelines and procedures for

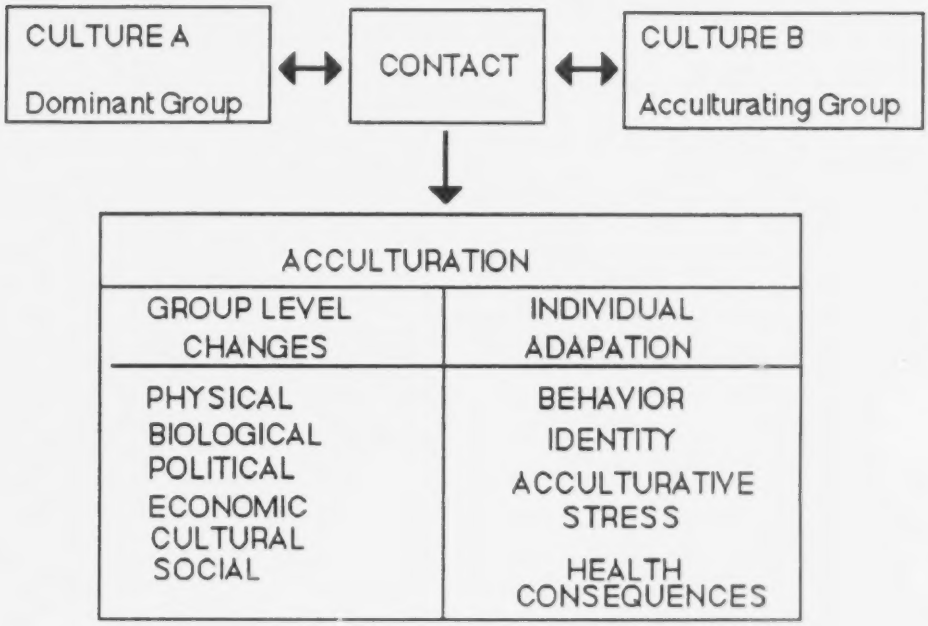
acculturation, social adjustment, and primary prevention of psychiatric disorder and maladjustment among refugees" (Objective 2.1.3).

It is obvious to all of us that a process of culture contact and change has been taking place for millennia, and continues at an ever-increasing pace. In the past, conquest and enslavement were common, while nowadays migration (both voluntary and enforced) is the predominant experience. Individuals and groups must somehow deal with this process in all its dimensions: political, economic, cultural, social and psychological. In this paper, the concepts of acculturation and adaptation will be employed to describe and analyze this overall chain of events from initial contact to the eventual mental health consequences for the individual. While the analysis is cast in general terms (that is, for all acculturating peoples), the assumption is made that the psychological processes of adaptation are similar among refugees and asylum seekers, and that we can better serve this special group by understanding the general phenomena of acculturation and psychological adaptation.

Acculturation

Acculturation is a term which has been defined as culture change that results from continuous, first hand contact between two distinct cultural groups (Redfield, Linton and Herskovits, 1936) (see Figure 1). While originally proposed as a group-level phenomenon, it is now also widely recognized as an individual level phenomenon, and is termed psychological acculturation (Graves, 1967). At this second level, acculturation refers to changes in an individual (both overt behavior and covert traits) whose cultural group is collectively experiencing acculturation. It is important to note here that mutual changes are implied in the definition: both groups experience changes, and both need to be understood. In the dominant group (Culture A), and among its individual members, attitudes and values may change in response to refugee arrivals, leading either to a more or to a less hospitable climate for refugee settlement. At the cultural level, economic and political institutions may also react to newcomers, political institutions may also react to newcomers, altering the suitability of the community for further settlement programs. While these changes in the dominant groups are essential to understand most changes occur in the non-dominant group (culture B) as a result of influence from the dominant

group (culture A). Included in these changes are those that are initiated by acculturation, but continue with a dynamic of their own without continuous influence from the dominant society. It is on these non-dominant (or acculturating) groups that we will focus in trying to link acculturation experience to psychological adaptation.



What kinds of changes may occur as a result of acculturation? First, physical changes may occur: a new place to live, a new type of housing, increasing population density, urbanization, more pollution etc, are all common with acculturation. Second, biological changes may occur: new nutritional status, and new diseases (often devastating in force) are all common. Third, political changes occur, usually bringing the non-dominant groups under some degree of control, and usually involving some loss of autonomy. Fourth, economic changes occur, moving away from traditional pursuits toward new forms of employment. Fifth, cultural changes (which are at the heart of the definition) necessarily occur: original linguistic, religious, educational and technical institutions become altered, or imported ones take their place. Sixth, social relationships become altered, including intergroup and inter-personal relations, and new patterns of dominance may appear. Finally, numerous psychological changes appear at

the individual level. Changes in behaviour are well documented in the literature (see Berry, 1980 for a review); these include, for example, changes in values, abilities and motives. Existing identities and attitudes change and new ones develop: self-attitudes (personal identity and ethnic identity) often shift away from those held prior to contact, and views about how (and whether) one should participate in the process of acculturation emerge (see Berry, Kim, Power, Young & Bujaki, 1986); other attitudes (such as intergroup attitudes and lifestyle preferences) also change and develop during acculturation.

Stress phenomena, and related pathology, both appear during acculturation (see Berry, Kim, Minde & Mok, 1987). While these negative and largely unwanted consequences of acculturation are not inevitable, and while there are also new opportunities to be encountered during acculturation, it is nevertheless the case that serious problems often do appear in relation to acculturation (Berry and Kim, 1988). It is our view that these problems reside in the interaction between the two groups in contact, and that they can be managed and ameliorated by identifying their specific source and by restructuring the relationships between the groups.

Adaptation

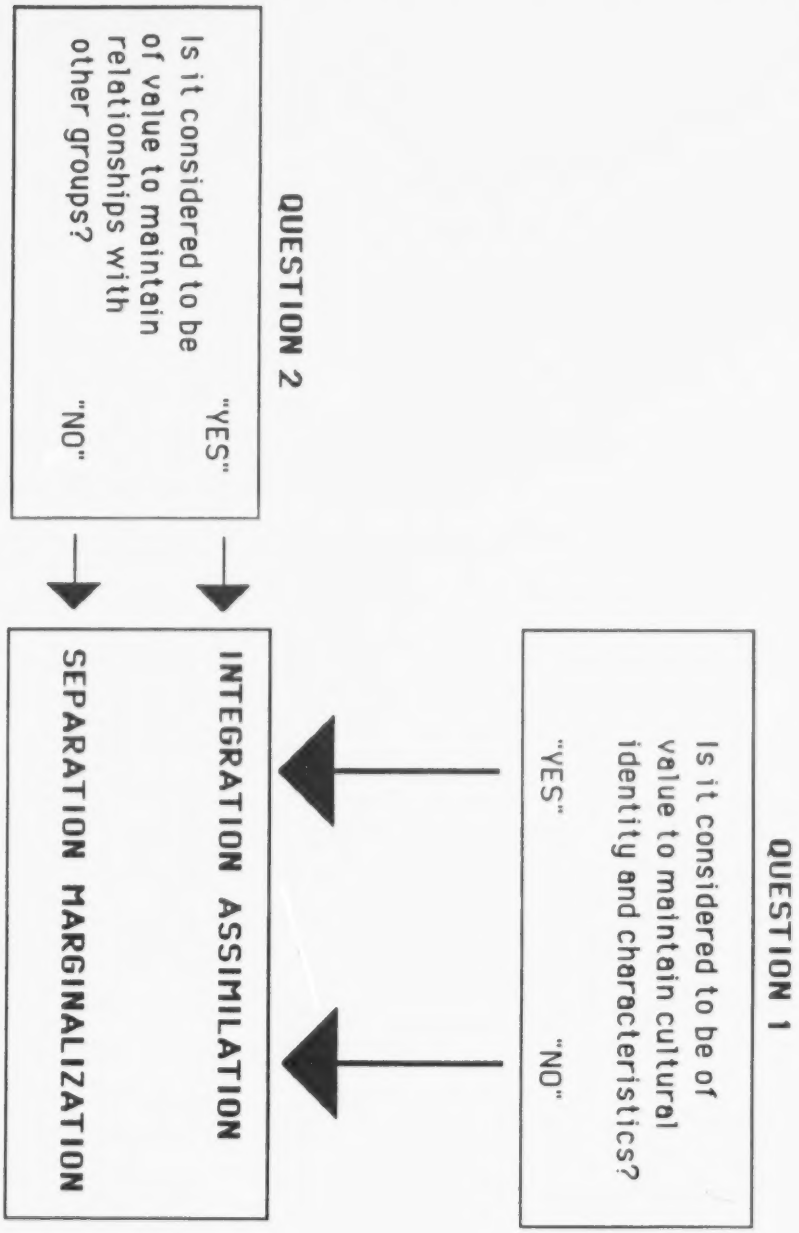
As employed here, adaptation is the generic term used to refer to both the process of dealing with acculturation and the long-term outcome of acculturation. At the outset, we need to recognize that the concept of adaptation has a long and complex history in the social and behavioral sciences: for psychologists, the usual concern is how individuals come to grips with the social, cultural or ecological setting in which they find themselves (Honigmann, 1976). In all disciplines, though, it is accepted that there are different strategies of adaptation (as a process) that lead to different varieties of adaptation (as an outcome). For the individual, three such strategies have been identified (Berry, 1976). These have been termed adjustment, reaction and withdrawal, and may be defined in the following way. In the case of adjustment, changes in the organism are in a direction which reduces the conflict (that is, increases the congruence or fit) between the environment and the organism by bringing it into harmony with the environment. In general, this strategy is the one most often intended by the term adaptation and may indeed be the most common form.

In the case of reaction, changes are in a direction which retaliates against the environment; these may lead to environmental changes which, in effect, increase the congruence or fit between the two, but not by way of cultural or behavioral adjustment. In the case of withdrawal, change is in a direction which reduces the pressures from the environment; in a sense, it is a removal from the adaptive arena, and can occur either by forced exclusion or by voluntary withdrawal. These three strategies of adaptation are similar to the distinctions in the psychological literature (Horney, 1955) made between moving with or toward, moving against and moving away from a stimulus.

It is important to note that the third strategy (withdrawal) is often not a real possibility for those being influenced by larger and more powerful cultural systems. And for the second strategy (reaction), in the absence of political power to divert acculturative pressures, many acculturating peoples cannot successfully engage in retaliatory responses. Thus, individual change in order to adapt to the context (some form of the adjustment strategy of adaptation) is often the only realistic alternative.

Just as there are strategies of adaptation, so too are there varying ways in which individuals can acculturate. Corresponding to the view that adjustment is not the only strategy of adaptation, we take the view that assimilation is not the only mode of acculturation. This position becomes clear when we examine the framework proposed by Berry (1984) (see Figure 2). The model is based upon the observation that in culturally plural societies, individuals and groups must confront two important issues. One pertains to the maintenance and development of one's ethnic distinctiveness in society; it must be decided whether one's own cultural identity and customs are of value and should be retained. The other issue involves the desirability of inter-ethnic contact, deciding whether relations with the larger society are of value and should be sought. These are essentially questions of attitudes and values and may be responded to on a continuous scale, from positive to negative. For conceptual purposes, however, they can be treated as dichotomous ("yes" or "no") decisions, thus generating a fourfold model (see Figure 2) that serves as the basis for our discussion. Each cell in this fourfold classification is considered to be an acculturation option (both a strategy and an outcome) available to

individuals and to groups in plural societies. These four options are Assimilation, Integration, Separation and Marginalization.



When the first question is answered "no", and the second is answered "yes", the Assimilation option is defined, namely, relinquishing one's

cultural identity and moving into the larger society. It can take place by way of absorption of a nondominant group into an established dominant group, or it can be by way of the merging of many groups to form a new society, as in the "melting pot" concept. This is clearly the variety that most closely resembles the adjustment form of adaptation.

The Integration option implies some maintenance of the cultural integrity of the group (that is, some reaction to acculturative pressures) as well as the movement to become an integral part of a larger societal framework (that is, some adjustment). Therefore, in the case of Integration, the option taken is to retain cultural identity and move to join with the dominant society. In this case, there are a number of distinguishable ethnic groups, all cooperating within a larger social system.

When there are no substantial relations with the larger society, accompanied by a maintenance of ethnic identity and traditions, another option is defined. Depending upon which group (the dominant or nondominant), controls the situation, this option may take the form either of Segregation or of Separation. When the pattern is imposed by the dominant group, segregation to keep people in "their place" appears, (that is, reaction followed by exclusion). On the other hand, the maintenance of a traditional way of life outside full participation in the larger society may be desired by the acculturating group and thus lead to an independent existence, as in the case of separatist movements (that is, reaction followed by withdrawal). In our terms, Segregation and Separation differ mainly with respect to which group or groups have the power to determine the outcome.

Finally, there is an option that is difficult to define precisely, possibly because it is accompanied by a good deal of collective and individual confusion and stress. It is characterized by striking out against the larger society and by feelings of alienation, loss of identity, and what has been termed acculturative stress (Berry & Annis, 1974). This option is Marginalization, in which groups lose cultural and psychological contact with their traditional culture and the larger society (either by exclusion or withdrawal). When imposed by the larger society, it is tantamount to ethnocide. When stabilized in a nondominant group, it constitutes the classical situation of marginality (Stonequist, 1937).

It is important to note that these various options may be pursued by politically dominant or non dominant groups. The model in Figure 2 can be employed at three distinct levels. First, at the level of the dominant or larger society, national policies can be identified as those encouraging Assimilation, Integration, Separation/Segregation or Marginalization. For example in Canada, the official policy is clearly towards Integration (termed "multiculturalism" by the Federal Government), while other societies' policies can be identified as being toward other alternatives, using this framework. Second, at the level of the non-dominant acculturating groups, these communities can articulate their wishes and goals, and communicate them to their members and to the larger society. Third, at the level of acculturating individuals, attitudes toward these four alternatives can be assessed using standard attitude measurement techniques, to obtain individual preferences about which mode of acculturation is most desirable (see Berry et al, 1986, for a review of some empirical studies of acculturation attitudes).

It is also important to note that both the acculturating groups and individuals experience flux in their attitudes toward acculturation; these changes can occur over time within an individual's lifetime, or over generations as descendents negotiate their way through the long-term process of adaptation to the larger society. For example, within the first generation, refugees may move from an initial preference for assimilation (perhaps associated with a sense of relief and gratitude), through a period of rejection (perhaps associated with confusion and hostility), to a final preference for integration; the literature does not provide evidence for a fixed sequence, merely for individuals' exploration of the various options before settling into one relatively stable mode of acculturation. Similarly, across generations, there is evidence of considerable change (often accompanied by intergenerational conflict over acculturation questions), but not consistent sequence that might be framed into a fixed set of "stages" of acculturation.

Acculturating Groups

Although many of the generalities found in the literature about the effects of acculturation have been based on a single type of group, it is

clear that there are numerous types, and adaptations may vary depending upon this factor.

In the review by Berry & Kim (1988), five different groups were identified including Immigrants, Refugees, Native Peoples, Ethnic Groups and Sojourners (see Figure 3). Among these types of groups, there are variations in the degree of voluntariness, movement and permanence of contact, all factors which might affect the health of members of the group.

Those who are voluntarily involved in the acculturation process (e.g., Immigrants) may experience less difficulty than those with little choice in the matter (e.g., Refugees and Native Peoples), since their initial attitudes toward contact and change may be more positive. Further, those only temporarily in contact and who are without permanent social supports (e.g., Sojourners) may experience more health problems than those more permanently settled and established (e.g., Ethnic Groups). These distinctions suggest some important variations in outcomes which have received some to empirical verification during the course of the research(Berry et al, 1987).

VOLUNTARINESS OF CONTACT

MOBILITY	VOLUNTARY	INVOLUNTARY
SEDENTARY	ETHNIC GROUPS	NATIVE PEOPLES
MIGRANT	IMMIGRANTS (relatively permanent) SOJOURNERS (temporary)	REFUGEES

Dominant Groups

Variations in dominant groups also exist, and these variations may have implications for the mental health of acculturating people. First, there are clear variations in the degree to which there is tolerance for the maintenance of cultural diversity. As Murphy (1965) has noted, tolerant

(pluralist, multicultural) societies do not generally force individuals to change their way of life, and usually have viable ethnic social support groups to assist individuals in the acculturation process. In contrast, monistic societies place more pressures on acculturating individuals to change, and often lack social supports for them. Both of these factors may have clear implications for the social and mental health of acculturating individuals.

Second, even in relatively pluralistic and tolerant societies, all ethnic groups are not equally accepted; variations in ethnic attitudes in the larger society (including levels of prejudice and acts of discrimination) are well-documented for Canada (Berry, Kalin & Taylor, 1977), and for many other countries.

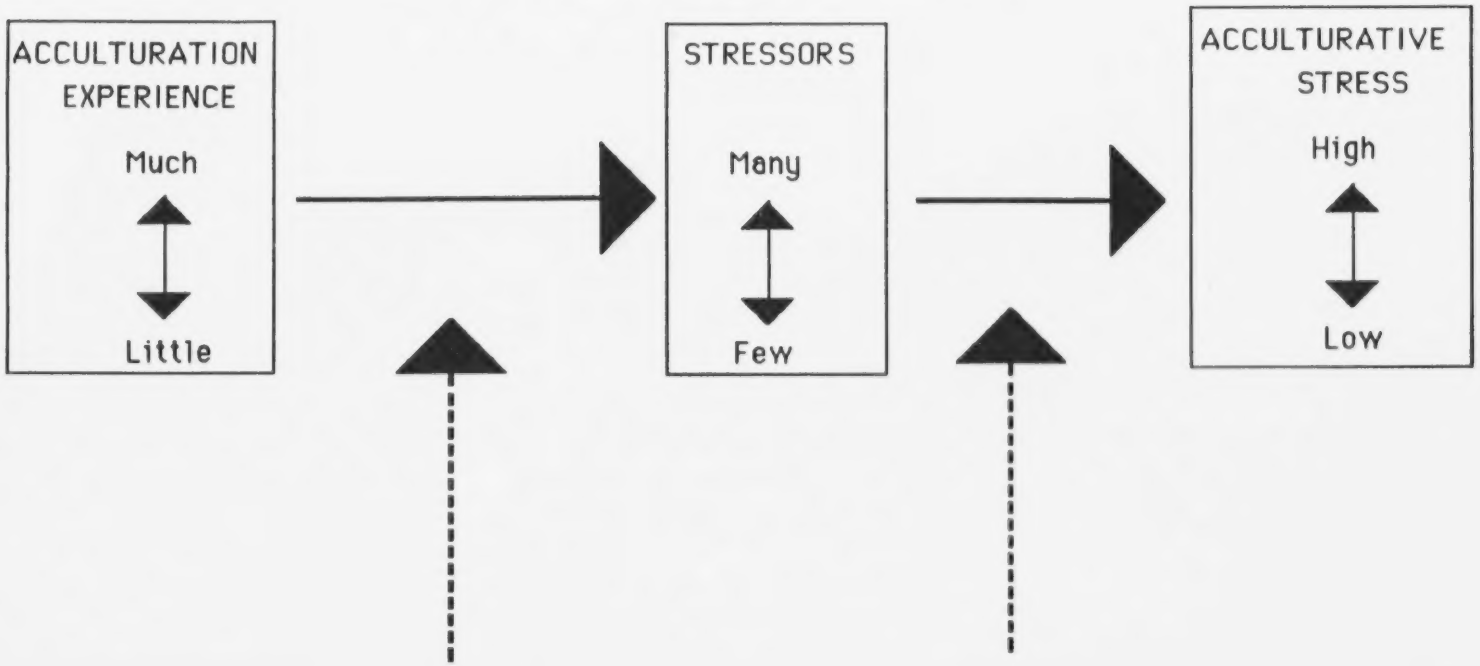
Acculturative Stress

The concept of stress has had wide usage in the recent psychological and medical literature (Selye, 1975, 1976) and it has sparked considerable controversy as well. There is no intention here to present a formal definition or conceptual model of stress. For the purposes of this paper, stress is considered to be a generalized physiological and psychological state of the organism, brought about by the experience of stressors in the environment, and which requires some reduction (for normal functioning to occur), through a process of coping until some satisfactory adaptation to the new situation is achieved. Stress is considered to be potentially bot a positive and negative phenomenon; some moderate level of stress may be necessary for individuals to function adaptively, while too little or too much may inhibit successful adaptation.

The concept of acculturative stress refers to one kind of stress, that in which the stressors are identified as having their source in the process of acculturation; in addition, there is often a particular set of stress-related behaviors which occur during acculturation, such as lowered mental health status (specifically confusion, anxiety, depression), feelings of marginality and alienation, heightened psychosomatic symptom level, and identity confusion. Acculturative stress is thus a phenomenon that may underlie a reduction in the health status of individuals (including physical, psychological and social aspects). However, acculturative stress may also underlie more positive adaptations, such as taking advantage of new

opportunities provided by contact with the larger society; thus, there can be no necessary prediction of psychological or social pathology on the basis of the presence of acculturative stress. Finally, to qualify as acculturative stress, these negative or positive outcomes should be related in a systematic way to known features of the acculturation process, as experienced by the individual.

In a recent review and integration of the literature, Berry and Kim (1988) attempted to identify the cultural and psychological factors which govern the relationship between acculturation and mental health. We concluded that clearly, mental health and social problems often do arise during acculturation; however, these problems are not inevitable, and seem to depend on a variety of group and individual characteristics which enter into the acculturation process. That is, acculturation sometimes enhances one's life chances and mental health, and sometimes virtually destroys one's ability to carry on; the eventual outcome for any particular individual is mediated by other variables that govern the relationship between acculturation and stress.



FACTORS MODERATING RELATIONSHIP BETWEEN ACCULTURATION AND STRESS
-Nature of the larger society (multicultural vs monocultural) -Type of acculturating group (immigrants, refugees, etc) -Modes of acculturation (Integration, Assimilation, Separation or Marginalization) -Demographic and social characteristics of individual (Age, Sex, Status, etc) -Psychological charcteristics of individual (Coping, Attitudes, etc)

This conception is illustrated in Figure 4. On the left of the figure, acculturation occurs in a particular situation (e.g., among refugees or in a native settlement), and individuals participate in and experience these changes to varying degrees; thus, individual acculturation experience may vary from a great deal to rather little. In the middle, stressors may result from this varying experience of acculturation; for some people, acculturative changes may all be in the form of stressors, while for others, they may be benign or even seen as opportunities. On the right, varying levels of acculturative stress may become manifest as a result of acculturation experience and stressors.

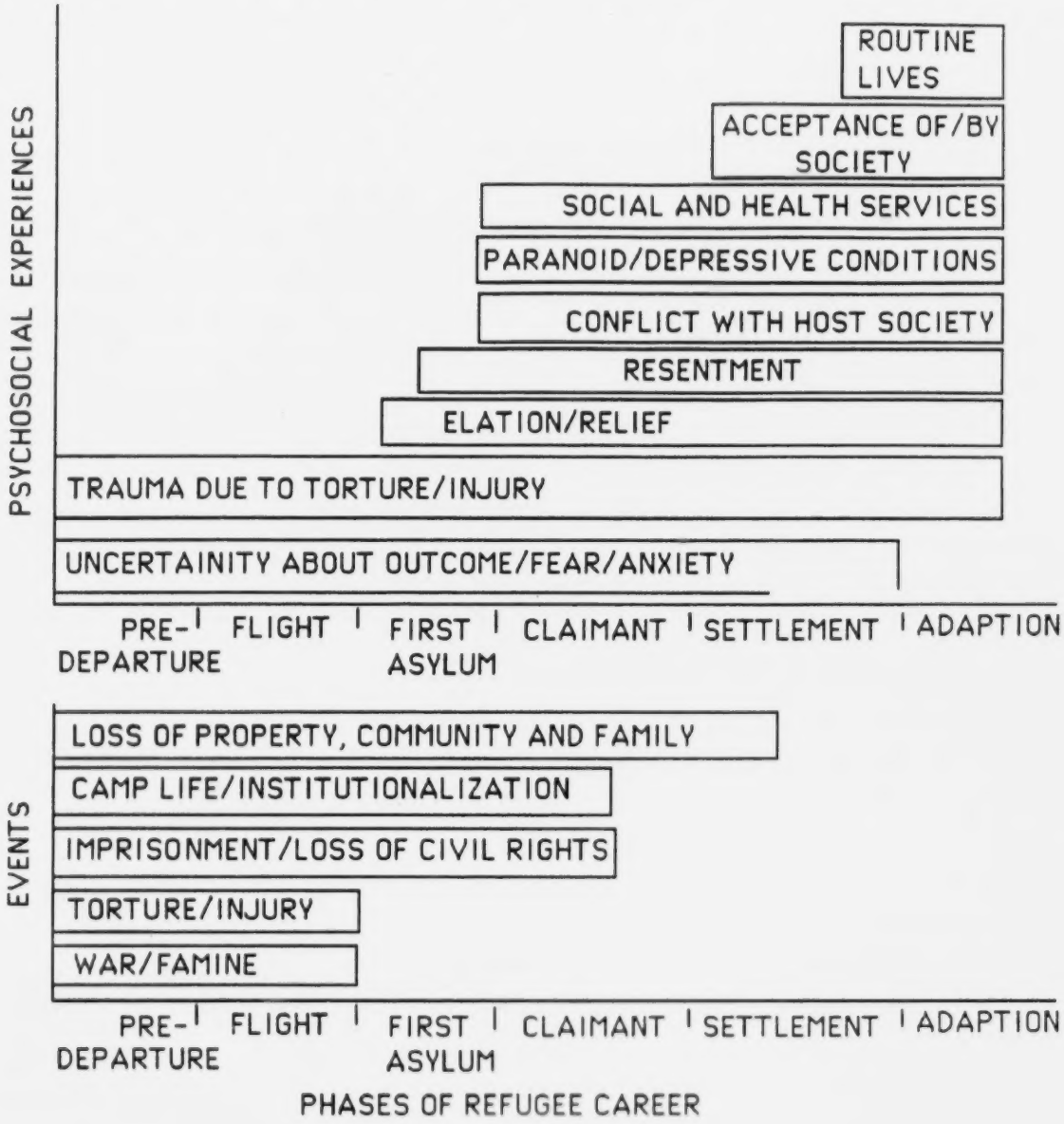
The first crucial point to note is that relationships among these three concepts (indicated by the solid horizontal arrows) are probabalistic, rather than deterministic; the relationships are likely to occur, but are not fixed. The second crucial point is that these relationships all depend upon a number of moderating factors (indicated in the lower box), including the nature of the larger society, the type of acculturating group, the mode of acculturation being experienced, and a number of demographic, social and psychological characteristics (including coping abilities) of the group and individual members. That is, each of these factors can influence the degree and direction of the relationships between the three variables at the top of Figure 4. This influence is indicated by the broken vertical arrows drawn between this set of moderating factors and the horizontal arrows.

One of these moderating factors, as we have already seen, is the nature of the host or larger society: is there a pluralist or multicultural ideology (with attendant tolerance for cultural diversity), or is there an assimilationist ideology (with pressures to conform to a single cultural standard)? As we have noted, arguments, and some evidence, exist (e.g., Murphy, 1965) that health problems may be less among immigrants in plural societies than in assimilationist ones. A clear implication is that dominant societies should avoid such assimilationist policies, and be tolerant of cultural differences in their populations.

Other variables identified by Berry and Kim (1988) were the nature of the acculturating group (Immigrants, Refugees, Native Peoples, Ethnic Groups and Sojourners), and modes of acculturation (Assimilation, Integration, Separation/Segregation and Marginalization) with respect to type of acculturating group, evidence suggests that Refugees and Native

Peoples experience greatest acculturative stress (Berry et al 1987), and social pathology. And with respect to attitudes individuals opting for Integration tend to experience less stress than those seeking Assimilation, but both are substantially less stressed than those seeking Separation or experiencing Marginalization. This implies that programs to encourage both cultural maintenance (through contact with ethnocultural communities) and involvement with the larger society (through settlement, language and employment activities) are to be preferred over assimilationist, separationist or marginalization policies.

Also implicated in the review are a variety of demographic, social and psychological characteristics of the individual. These individual and group differences are generally in the domain of "psychosocial factors" (WHO, 1979) and include characteristics such as pre-migration experiences (such as war, torture or famine), prior cultural knowledge and encounters (essentially a form of "pre-acculturation"), age, gender, marital status, social supports (both within the migrant group, and within the host society), a sense of "cognitive control" that one has over the acculturation process, and the degree of congruity between one's expectations about the acculturation process, and the realities one has encountered during the process. Of particular importance among these psychological factors is the individual's ability to cope with acculturative experience; individuals are known to vary widely in how they deal with major changes in their lives (Lazarus & Folkman, 1984), resulting in large variation in the level of stress experienced. Many other factors appear in the literature, but in our review these seemed to be the most theoretically relevant, and empirically- consistent, predictors of acculturative stress. Other factors, such as speed of acculturation, however, appear to have no consistent predictive value.



Phases of Acculturation

Experiences that are related to psychological acculturation and eventual adaptation may be classified sensibly according to the time (or phase) at which they take place. Such a classification should not be taken to imply that there is a standard experience or that it takes place at a standard pace or within a set period of time, but it is important to know where an individual refugee is in such a sequence in order to understand

part, and probably future, experiences and their mental health implications. For Refugees, these phases may be termed: Pre-Departure; Flight; First Asylum; Claimant Period; Settlement Period; and Adaptation. In each phase there are some events that are unique (e.g., torture), and some that are common with other phases (e.g., loss of community). In this section we attempt to identify these characteristic events, to place them in a generalized time frame (see bottom part of Figure 5), and to consider the characteristic psychological experiences and social problems that accompany these events (see upper part of Figure 5).

Pre-Departure. In the pre-departure period there exist the most traumatic events that put refugees at risk for later development of mental and social problems. Ironically, it is these very high risk factors that are least amenable to prevention by those in the mental health field. However, international and civil wars, revolutions, famines and ecological disasters are not "natural" events; they are the result of human action, and are thus amenable to human counter-action. The largest refugee dislocations at the present time are those due to military interventions (either direct or indirect) by major world powers, and to the long and painful process of decolonization; these are both acculturation experiences of the most dominating kind. A fundamental programme in primary prevention, then, would be one that addresses these macroproblems on an international scale; and we in refugee-receiving countries are in a position to bring about some amelioration.

Within nation states, other more direct factors are evident: ethnic, racial, and religious conflict and persecution, political violence, imprisonment and deliberate torture (Barudy, 1987; Horvath, 1987) all become compounded in the accumulation of pre-departure trauma. These situations are not in essence due to acculturation but they too, are the result of human actions, and in principle are subject to human counter-action. Primary prevention is thus not beyond contemplation; however, we in receiving nations may be less capable of improving these largely internal situations.

In short, fundamentally important events in the experience of trauma are least within our primary prevention purview as mental health professionals, but they can be addressed in public from our professional

platforms. Common sense suggests that we should be addressing these big but difficult issues at the same time as we attempt to deal with the relatively small but more accessible ones. Making daily repairs to continually- breaking parts of a faulty machine is of limited long-term usefulness.

Flight. During flight the trauma usually continues, with the same attendant risks of capture (or recapture), privation, starvation and of physical injury, torture, even death. Loss of property, community and family, and uncertainty of what awaits one at the end of the journey, have direct psychological impact. Once again, primary prevention is difficult if not impossible during flight, but improving knowledge of the usual experiences during this phase on the part of mental health professionals should enhance the usefulness of later primary prevention.

First Asylum. Immediate elation and relief are often experienced on arrival in first asylum situations; however, this is usually accompanied by fresh problems in this new acculturation arena. In border areas especially, fear for personal safety continues, as well as uncertainty. For most, some sort of camp, even imprisonment, also continues. Although first asylum is, in principle, available to all who physically arrive, both at this phase and at the next point (claimant phase) the refugee is subject to deportation to either one's country of origin, or to another country of first asylum. On the recognition that most of one's problems are likely to continue for many years, elation and relief may give way to resentment about one's condition, and to a resurgence of uncertainty, fear and anxiety: this has been termed "delayed psychology entry" by Tyhurst (1980).

During camp or community life in the phase of first asylum, some primary prevention is possible (Fozzard, 1987). However, safety and physical needs are usually paramount, and psychological needs may go unexpressed, unidentified and unmet. Retrospective accounts by refugees and previous experiences of camp-working professionals can provide much needed information for the development of primary mental health programmes at this phase.

Claimant. On arrival in a country of potential settlement, a third acculturation arena is experienced. In these situations, all claimants for refugee status are in principle,entitled to be granted asylum by countries

who have signed the UN convention. In practice, however, many are turned away, and knowledge of this possibility can raise uncertainty and fear to unbearable levels. If deportation is ordered, the claimant is often left entirely without support, and attempted suicide is not uncommon. If asylum is granted, elation and relief continue, often followed by resentment at being in limbo between flight and settlement. Conflict with officials and sometimes hostile citizens of the host society also frequently develops. Depending on the host country, there is large variation in work rules, educational possibilities, and the n availability of health and social services during this phase. In one formulation, this is a severely marginalized situation, in which very high levels of acculturative stress can begin to appear (as distinct from the stress of flight). In extreme cases, paranoid conditions and depression become common during this phase.

Primary prevention may be particularly effective here; however, social and health care may be unavailable, or be in dispute among authorities. Even effectively-functioning or professionally-trained individuals within the refugee community may be prevented from acting on behalf of fellow refugees, in some countries. Despite these impediments, the claimant period offers the most available time period for prevention work. For it is here where there exists a set of necessary preconditions: relative safety, met physical needs, some degree of settled life, useable time, and (potentially) available services. Refugee-receiving countries may be able to make best use of their humanitarian resources during this phase, even if all claimants will not eventually be admitted.

Settlement. By far most primary prevention is possible here, for at this point the host society formally accepts the refugee as a potential citizen, usually with all the rights and freedoms granted to citizens. Unfortunately, as pointed out by many observers (e.g., Westermeyer, 1987; Williams, 1987) many settlement programmes have not taken advice from mental health professionals, have not learned from previous refugee waves, and have not been formally evaluated. In some cases settlement policies have been downright wrong: scattering or dispersal, and social unit (informal "family") breakup policies wipe out needed social support, and induce assimilation; sponsors have sought cheap labour or converts; services are culturally inappropriate, service providers are culturally

ignorant or insensitive, and services may be much too short-lived to be of value.

Despite these problems, reports from Western Europe, Canada and the U.S. indicate that most refugees settle without serious difficulty, given basic minimal services of language training, initial social and monetary support and cultural orientation to the new society: that is, there is a gradual acceptance of, and by, the host society. Those with particularly traumatic histories, however, still need to be identified early and validly, using culturally-appropriate instruments, and culturally-sensitive personnel. Thus, during the settlement phase the needs are twofold: basic preventive services for the whole refugee population (including screening), and specialized services for those at particular risk.

Adaptation. While not all refugees eventually find a satisfactory long term adaptation to their new society, most do, and settle into routine lives. For those that do not, there may be a need for continuing services that are normally provided during the settlement period. Evidence from earlier waves of migrants from Europe and elsewhere (e.g., Hungary, Uganda, Chile, Cuba) suggests that the long-term prognosis is rather good. However, comparisons and generalizations like this ignore variations in many of the factors identified earlier in Figure 4, and caution is necessary. One source of caution is particularly relevant: in the past few years elderly refugees from earlier waves have begun to appear for mental health services, suggesting that a stable adaptation may be only a temporary achievement (Rack, 1987).

Implications for Refugees

The factors associated with refugee mental health in this overview, are just that - "associated". We have relied upon correlational and observational data; in the virtual absence of longitudinal and evaluation studies and the complete absence of experimental studies that may link cause and effect together in a more formal way, we can take as only hints or suggestions that certain conditions may lead to certain outcomes. As replications build up, and as comparative studies permit the teasing out of specific factors from each other, we may claim more and more validity; but the field of refugee mental health is inherently incapable of experimental attack. Thus, it is necessary to keep these limitations in mind when asserting some basis for policy action.

With these cautions in mind, we may make a number of observations and assertions. First, viewed in the light of these general principles and processes of acculturation and psychological adaptation, refugees and asylum seekers are clearly more at risk than other groups of acculturating peoples. This position, (which may be self-evident to most of you here) needs to be firmly established and the evidence clearly understood if remedial action (in terms of policies and programmes) are to be developed, accepted and implemented.

Reviewing the general framework which has been presented, with a specific focus on refugees, we may note the following:

Figure 1. Dominant groups are often very dominant with respect to a relatively powerless group of refugees: this imbalance may be seen in all three acculturation areas (pre-departure, fist asylum and settlement). Demographic, military, political and economic power imbalance is likely to produce an extremely difficult situation for refugees. In turn, group level changes, including physical conditions (housing, safety), malnutrition and sanitary conditions, political isolation, economic loss, and cultural and social disintegration are likely to be much worse for refugees than for any other type of acculturating group. Individual adaptations are consequently also likely to be extreme, with major changes in daily behavior (due to loss of independence, in sometimes prison-like conditions), identity loss and confusion, and the probability of intense levels of stress. Health consequences, but in particular mental health problems, are thus most likely to be extreme for refugees and asylum seekers.

Figure 2. Countries of first asylum may be those that are least able (politically or economically) to permit full participation of the new arrivals; hence the Assimilation and Integration modes of acculturation are less likely to occur than the Segregation or Marginalization options (e.g. camps). This reality places certain limitations on the choices that refugees themselves can make, and any discrepancy between one's own preferences and those permitted by the host society are likely to create stressors for the refugees.

Figure 3. The research literature has clearly shown that the two factors of voluntariness and mobility are important in stress induction. It is obvious that refugees are getting the worst from both of these conditions, leading to the expectation that stress will be greater for them than for any

other kind of acculturating group. Lacking positive motivation ("pull factors") to move (and with an abundance of "push factors"), and being unable to maintain a supportive political, economic and sociocultural context, refugees are forced to exist in the worst of all acculturating worlds. Moreover, like sojourners, asylum seekers must live with a temporary and uncertain status, leading to extra stressors.

Figure 4. At the crux of the analysis is the probabalistic sequence: acculturation experiences - stressors - acculturative stress (moderated by numerous contextual and psychological factors). Without enumerating once again those variables identified in Figures 1 to 3, it is clear that almost all of the probabalistic factors in Figure 4 are weighted against a positive adaptation for refugees and asylum seekers, and are likely to lead to psychological and social problems.

Figure 5. The time course of being a refugee clearly places the major stressors at the beginning, with the possibility of improvement later. Countries of first asylum, and the eventual countries of settlement can choose to either assist in this improvement, or they can perpetuate the trauma by bringing new stressors to bear on the refugee. It appears that refugee policies and programmes may have come closer to the latter alternative, whether intended or not.

Conclusions

Despite this rather negative observation, most of the factors identified here are under some degree of control by those responsible for initiating the three acculturation contexts: that is by those creating a refugee situation in the first place, by those serving as countries of first asylum, by those serving as resettlement countries;there is also the possibility of some control by the refugees themselves. Each of these points of entry into the problems can serve as a point of partial control over the sequence. Armed with a knowledge of the acculturation process, and of the critical variables involved, effort can be made to alter the probabilities toward more positive adaptations. It is, of course, a monumental task, but it is a possible one.

It is important to remember that no psychological finding (or theory or method) can be transported or generalized to other cultures. Thus, the present overview is intended to stimulate and to challenge research on psychological acculturation and refugee adaptation, rather than to be

taken uncritically as the proper way to do things, or as a statement of the inevitable outcomes of acculturation. Variations, due to factors in the host society, in the acculturating group, and to individuals involved in the process, will all make the results highly variable from one society, group, and person to another.

References

Barudy, J. (1987). Psychotherapy Among Latin American Torture Victims in Belgium. Paper presented at Workshop on Refugee Children's Mental Health. Refugee Studies Centre, Oxford University.

Berry, J.W. (1976). Human Ecology and Cognitive Style: Comparative Studies in Cultural and Psychological Adaptation. London: Sage.

Berry, J.W. (1980). Social and cultural change. In: H.C. Triandis and R.

Brislin (Eds.), Handbook of Cross-Cultural Psychology, Vol. 5, Social. Boston: Allyn and Bacon.

Berry, J.W. (1984). Cultural relations in plural societies: Alternatives to segregation and their sociopsychological implications. In N. Miller and M. Brewer (Eds), Groups in Contact. New York: Academic.

Berry, J.W. (1986). The acculturation process and refugee behavior. In C.L. Williams & J. Westermeyer (Eds), Refugee Mental Health in Resettlement Countries. Washington: Hemisphere.

Berry, J.W. & Annis, R.C. (1974). Acculturative stress. Journal of Cross-Cultural Psychology, 5, 382-406.

Berry, J.W., Kalin, R. & Taylor, D.M. (1977). Multiculturalism and Ethnic Attitudes in Canada. Ottawa: Government of Canada.

Berry, J.W. & Kim, U. (1988). Acculturation and mental health. In: P. Dasen, J.W. Berry and N. Sartorius (Eds) Health and Cross-Cultural Psychology; Towards Applications. London: Sage.

Berry, J.W., Kim, U., Minde, T., & Mok, D. (1987). Comparative studies of acculturative stress. International Migration Review, 21, 491-511.

Berry, J.W., Kim, U. Power, S. Young, M. & Bujaki, M. (1986). Acculturation attitudes in plural societies. Unpublished paper.

Berry, J.W., Trimble, J. & Olmeda, E. (1986). The assessment of acculturation. In: W.J. Lonner & J. W. Berry (Eds.), Field Methods in Cross-Cultural Research. London: Sage.

Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1986). Review of the Literature on Migrant Mental Health. Vancouver: UBC, Dept. of Psychiatry.

Fozzard, S. (1987). Mental Health and Social Programmes in Closed Refugee Camps in Hong Kong. Paper presented at Workshop on Psychological Problems of Refugees and Asylum Seekers, Vitznau, Switzerland.

Graves, T. (1967). Psychological acculturation in a tri-ethnic community, South-western Journal of Anthropology, 23, 337-350.

Honigmann, J.J. (1976). Personal adaptation as a topic for cultural and social anthropological research. Chairman's paper, Symposium on "The Concept of Adaptation in Studies of American Native Culture Change", American Anthropological Association, Washington.

Horney, K. (1955). As quoted in R. Munroe, Schools of Psychoanalytic Thought New York: Holt.

Horvath, J. (1987). Swedish Red Cross Centre Programme for the Rehabilitation of Torture Victims. Paper presented at Worshop on Psychological Problems of Refugees and Asylum Seekers, Vitznau, Switzerland.

Lam, L. (1987). Prevention of mental health problems in refugees. Refugee Mental Health Newsletter, 1, 9-11.

League of Red Cross and Red Crescent Societies (1986). Refugees and Displaced Persons in Africa. Geneva: League.

League of Red Cross and Red Crescent Societies (1987). Psychological Problems of Refugees and Asylum Seekers. Geneva: League.

Murphy, H.B.M. (1965). Migration and the major mental disorders: A reappraisal. In: M.B. Kantor (Ed.), Mobility and Mental Health. Springfield: Thomas.

Rack, P. (1987). Recent Work with Elderly Refugees in the U.K.. Paper presented at Workshop on Psychological Problems of Refugees and Asylum Seekers, Vitznau, Switzerland.

Redfield, R., Linton, R. & Herskovits, M.J. (1936). Memorandum on the study of Acculturation. American Anthropologist, 38, 149-152.

Refugee Action (1987). Report on Seminar on The Psychological Problems of Refugees and Asylum Seekers in the Context of Industrialised Countries. London: British Red Cross.

Selye, H. (1975). Confusion and controversy in the stress field. Journal of Human Stress, 1, 37-44.

Selye, H. (1976). The Stress of Life (Rev. Ed.). New York: McGraw-Hill.

Stonequist, E.V. (1937). The Marginal Man. New York: Scribner's.

Tyhurst, L. (1980). Refugee resettlement. Paper presented at Second Pacific congress of Psychiatry, Philippines.

Westermeyer, J. (1986). Migration and psychopathology. In C.L. Williams & J. Westermeyer (Eds.), Refugee Mental Health in Resettlement Counties. Washington: Hemisphere.

Westermeyer, J. (1987). Prevention of mental disorder among refugees in the U.S.: Lessons from the period 1976-1986. Social Science and Medicine, 25, 941-947.

Williams, C.L. (1987). Prevention programs in mental health for refugees. Unpublished paper, University of Minnesota.

World Health Organization (1979). Psychosocial factors and health: New programme directions. In: P. Ahmed & G. Coelho (Eds), Toward a New Definition of Health, New York: Plenum.